

Defendants.

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6. On October 16, 2012, I performed an Employment Physical Examination of Railo.

7. Annexed hereto as **Exhibit A** is a true and complete copy of the Report documenting my October 16, 2012 Employment Physical Examination of Railo.

8. That report was prepared by me as a result of my examination of Railo; information provided to me by Railo; and, information obtained from Railo's primary care physician, Vivianna Galli, M.D.

9. During my examination of her, Railo denied narcotic or habit forming drug use.

10. During my examination of her, Railo exhibited no signs or symptoms of narcotic or habit forming drug use.

11. During my examination of her, Railo disclosed that she was then prescribed the medications Clonidine and Diazepam.

12. At no time during my examination of her, did Railo disclose to me that she was prescribed Suboxone. Had Railo disclosed to me that she was prescribed Suboxone, or any other medication for that matter, I would have written it in my report because I write down all medications which are disclosed. The only medications that Railo disclosed to me were Clonidine and Diazepam.

13. As a result of Railo disclosing that she was prescribed Clonidine and Diazepam, I forwarded to the prescribing physician, Dr. Galli, a form Prescription Clearance Letter to determine whether either/both of those medications would affect Railo's ability to drive a school bus.

14. On October 16, 2012, Dr. Galli returned the fully executed Prescription

Clearance Letter to Partners in Safety, verifying that the medications of Clonidine and Diazepam were only taken during non-work hours. Dr. Galli certified, in her professional judgment, those medications will not affect Railo's ability to safely operate a commercial motor vehicle.

15. Annexed hereto as **Exhibit B** is a true and complete copy of the Prescription Clearance Letter certified by Dr. Galli received by Partners in Safety on October 16, 2012.


16. This Prescription Clearance Letter is an internal document received and maintained by Partners in Safety which is used during its internal certification process, and was not forwarded to Quality.

17. Based on the foregoing, I determined that there was no medical reason which would prevent Railo from becoming certified as a school bus driver. As such, I certified that I examined Railo in accordance with the Federal Motor Carrier Safety Regulations, and determined that she was qualified to drive a school bus.

Dated: September 21, 2015


PATRICIA AMES, NP

Sworn to before me this
21 day of September, 2015.


Notary Public

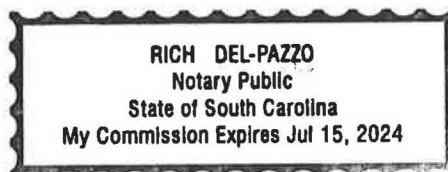


EXHIBIT “A”

1. DRIVERS INFORMATION Driver completes this section.

Driver's Name (Last, First, Middle) <u>Railo, Cathin, Helen</u>	Social Security No. <u>5139</u>	Birth date <u>M/D/Y</u>	Age <u>31</u>	Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	<input checked="" type="checkbox"/> New Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Follow Up	Date of Exam <u>10/10/12</u>
Address (Street) <u></u>	City, State, Zip Code <u></u>	Phone W: <u>(845) 858-2150</u> H: <u>(845) 331-2335</u>	Driver's License No. <u></u>	License Class <input type="checkbox"/> A <input checked="" type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> Other	State of Issue <u>NY</u>	

2. HEALTH HISTORY Driver completes this section, but medical examiner is encouraged to discuss with driver.

<p>Yes No</p> <p><input checked="" type="checkbox"/> <input type="checkbox"/> Any illness or injury in last 5 years.</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Head/Brain injuries, disorders, or illnesses</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Seizures, epilepsy <input type="checkbox"/> medication <u></u></p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Eye disorders or impaired vision (except corrective lenses)</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Ear disorders, loss of hearing or balance</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Heart disease or heart attack; other cardiovascular condition <input type="checkbox"/> medication <u></u></p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Heart surgery (valve replacement / bypass, angioplasty, pacemaker)</p>	<p>Yes No</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> High Blood Pressure <input type="checkbox"/> medication <u></u></p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Muscular disease</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Lung disease, emphysema, asthma, chronic bronchitis</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Kidney disease, dialysis</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Liver disease</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Diabetes or elevated blood sugar controlled by: <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Nervous or psychiatric disorders, e.g., severe depression <input type="checkbox"/> medication <u></u></p>	<p>Yes No</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Loss of, or altered consciousness</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Fainting, dizziness</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Sleep disorders, pauses in breathing while asleep, daytime sleepiness, loud snoring</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Stroke or paralysis</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Missing or impaired hand, arm, leg, finger, toe</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Spinal injury or disease</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Chronic low back pain</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Regular, frequent alcohol use</p> <p><input type="checkbox"/> <input checked="" type="checkbox"/> Narcotic or habit forming drug use</p>
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For any YES answer, indicate onset date, diagnosis, treating physician's name and address, and any current limitation. List all medications (including over-the-counter medications) used regularly or recently.

May 2012 had a hysterectomy due to cervical cancer. DR KOENIG
(currently on clonidine for menopause hot flashes, etc.) and Valium

Dr. Rhenler
95 Crystal Run Road

Middlebrook, NY 10940

No current limitations

I certify that the above information is complete and true. I understand that inaccurate, false or missing information may invalidate the examination and my Medical Examiner's Certificate.

Cathin Railo

Driver's Signature

10/10/2012

Date

Medical Examiner's Comments on Health History (The medical examiner must review and discuss with the driver any "Yes" answers and potential hazards of medications, including over-the-counter medications, while driving.)

PMH: - Cervical TAA - 5/12.

PSH: - 2006 Breast Cancer, Ovarianectomy & chemo pills

Med(s): Clonidine 1mg po BID, DIAZAPAM 10mg po 2-3x/day

TESTING (Physical Examiner completes Section 3 through 7) PMD Dr. Galli

3. VISION Standard: At least 20/40 acuity (Snellen) in each eye with or without correction. At least 70° peripheral in horizontal meridian measured in each eye. The use of corrective lenses should be noted on the Medical Examiner's Certificate.

INSTRUCTIONS: When other than the Snellen chart is used, give test results in Snellen-comparable values. In recording distance vision, use 20 feet as normal. Report visual acuity as a ratio with 20 as numerator and the smallest type read at 20 feet as denominator. If the applicant wears corrective lenses, these should be worn while visual acuity is being tested. If the driver habitually wears contact lenses, or intends to do so while driving, sufficient evidence of good tolerance and adaptation to their use must be obvious. Monocular drivers are not qualified.

Numerical readings must be provided.

ACUITY	UNCORRECTED	CORRECTED	HORIZONTAL FIELD OF VISION
Right Eye	20/ <u>20</u>	20/ <u></u>	Right Eye <u>80</u> °
Left Eye	20/ <u>20</u>	20/ <u></u>	Left Eye <u>80</u> °
Both Eyes	20/ <u>20</u>	20/ <u></u>	<u>100</u> °

Applicant can recognize and distinguish among traffic control signals and devices showing standard red, green and amber colors? ☒ Yes ☐ No

Applicant meets visual acuity requirement only when wearing: ☐ Corrective Lenses

Monocular Vision: ☐ Yes ☒ No

Complete next line only if vision testing is done by an ophthalmologist or optometrist

Date of Examination

Name of ophthalmologist or optometrist (please print)

Telephone Number

License No./ State of Issue

Signature

N Numerical readings must be recorded.

a) Record distance from individual at which forced whispered voice can first be heard.	Right Ear	Left Ear
	5 Feet	5 Feet

b) If audiometer is used, record hearing loss in decibels. (acc. To ANSI Z24.5-1951)

Right Ear			Left Ear		
500 Hz	1000 Hz	2000 Hz	500 Hz	1000 Hz	2000 Hz
Average:			Average:		

5. BLOOD PRESSURE/PULSE RATE

Numerical readings must be recorded. Medical Examiner should take at least two readings to confirm Blood Pressure.

Blood Pressure	Systemic	Diastolic
	122	80

Reading	Category	Expiration Date	Recertification
140-159/90-99	Stage 1	1 Year	1 Year if $\leq 140/90$ One-time certificate for 3 mos. if 141-159/91-99
160-179/100-109	Stage 2	One-time certificate for 3 mos.	1 Year from date of exam if $\leq 140/90$
$>180/110$	Stage 3	6 mos. From date of exam if $\leq 140/90$	6 mos. If $\leq 140/90$

D Driver qualified if $\leq 140/90$.

Pulse Rate: <input checked="" type="checkbox"/> Regular <input type="checkbox"/> Irregular
Record Pulse Rate: 62

6. LABORATORY AND OTHER TEST FINDINGS

Urinalysis is required. Protein, blood or sugar in the urine may be an indication for further testing to rule out any underlying medical problem.

Numerical readings must be recorded.

Other Testing (Describe and record)

URINE SPECIMEN	SP. GR.	PROTEIN	BLOOD	SUGAR
1305	NEG	NEG	NEG	NEG

7. PHYSICAL EXAMINATION

Height: 66 (in.) Weight: 170 (lbs.)

The presence of a certain condition may not necessarily disqualify a driver, particularly if the condition is controlled adequately, is not likely to worsen or is readily amenable to treatment. Even if a condition does not disqualify a driver, the medical examiner may consider deferring the driver temporarily. Also, the driver should be advised to take the necessary steps to correct the condition as soon as possible particularly if the condition, if neglected, could result in more serious illness that might affect driving.

Check YES if there are any abnormalities. Check NO if the body system is normal. Discuss any YES answers in detail in the space below, and indicate whether it would affect the driver's ability to operate a commercial motor vehicle safely. Enter applicable item number before each comment. If organic disease is present, note that it has been compensated for. See instructions to the Medical Examiner for guidance.

BODY SYSTEM	CHECK FOR:	YES*	NO	BODY SYSTEM	CHECK FOR:	YES*	NO
1. General Appearance	Marked overweight, tremor, signs of alcoholism, problem drinking, or drug abuse.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	7. Abdomen and Viscera	Enlarged liver, enlarged spleen, masses, bruits, hernia, significant abdominal wall muscle weakness.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Eyes	Pupillary equality, reaction to light, accommodation, ocular motility, ocular muscle imbalance, extraocular movement, nystagmus, exophthalmos, strabismus uncorrected by corrective lenses, retinopathy, cataracts, macular degeneration, aphakia, glaucoma.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	8. Vascular System	Abnormal pulse and amplitude, carotid or arterial bruits, varicose veins.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Ears	Middle ear disease, occlusion of external canal, perforated eardrums.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	9. Genito-urinary System	Hemias	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Mouth and Throat	Irremediable deformities likely to interfere with breathing or swallowing.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	10. Extremities-Limb impaired.	Loss or impairment of leg, foot, toe, arm, hand, finger. Perceptible limp, deformities, atrophy, weakness, paralysis, clubbing, edema, hypotonia. Insufficient grasp and prehension in upper limb to maintain steering wheel grip. Insufficient mobility and strength in lower limb to operate pedals properly.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Heart	Murmurs, extra sounds, enlarged heart, pacemaker.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	11. Spine, other musculoskeletal	Previous surgery, deformities, limitation of motion, tenderness.	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Lungs and chest, not including breast examination.	Abnormal chest wall expansion, abnormal respiratory rate, abnormal breath sounds including wheezes or alveolar rates, impaired respiratory function, dyspnea, cyanosis. Abnormal findings on physical exam may require further testing such as pulmonary tests and/or x-ray of chest.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	12. Neurological	Impaired equilibrium, coordination or speech pattern; paresthesia, asymmetric deep tendon reflexes, sensory or positional abnormalities, abnormal patellar and Babinski's reflexes, ataxia.	<input type="checkbox"/>	<input checked="" type="checkbox"/>

*Comments: Slight PRD x 15 years & CTO H & Drugs

This section MUST be completed. See Instructions to the Medical Examiner for guidance.

☒ Meets standards in 49 CFR 391.41; qualifies for 2 year certificate

☐ Does not meet standards.

☐ Meets standards, but periodic monitoring required

Due to _____ driver qualified only for:

☐ 3 Months ☐ 6 Months ☐ 1 Year ☐ Other

☐ Temporarily disqualified due to (condition or medication): _____

Return to medical examiner's office for follow up on _____

☐ Driving within an exempt intracity zone (SEE 49 CFR 391.62)

☐ Qualified by operation of 49 CFR 391.64

☐ Wearing corrective lenses

☐ Wearing a hearing aid

☐ Accompanied by a _____ waiver/exemption

Driver must present exemption at time of certificate

☐ Skill Performance Evaluation (SPE) Certificate

Medical Examiner's Signature _____

Medical Examiner's Name (print) _____

Address _____

Telephone Number _____

Certificate Expiration Date _____

Date of Exam 10/16/12

I certify that I have examined _____ (Candidate Name) and with knowledge of the driving requirements with the Federal Motor Carrier Safety Regulations (49 CFR 381.41-381.43) and with knowledge of the driving rules, I have found that _____ (Candidate Name) is qualified to drive a commercial motor vehicle.

☐ wearing corrective lenses ☐ driving within an exempt intrastate zone (49 CFR 381.52)

☐ wearing hearing aid ☐ accompanied by a Self Performance Evaluation Certificate (SPE)

☐ accompanied by a _____ ☐ accompanied by operation of 49 CFR 381.64

The information I have provided regarding this physical examination is true and complete. A complete examination form with any attachments embodies my finding completely and correctly, and it is on file in my office.

SIGNATURE OF MEDICAL EXAMINER <i>Patricia Ames</i>	TELEPHONE	DATE 10/16/14
MEDICAL EXAMINER'S TITLE Patricia Ames, NP	<input type="checkbox"/> Physician Assistant <input checked="" type="checkbox"/> Chiropractor	<input type="checkbox"/> Advanced Practice Nurse
MEDICAL EXAMINER'S LICENSE NO. <i>1015000001</i>	STATE	
SIGNATURE OF DRIVER <i>Charles Paul</i>	DRIVER'S LICENSE NO.	STATE NY
MEDICAL CERTIFICATE EXPIRATION DATE		10/16/14

PARTNERS IN SAFETY, INC.

EXHIBIT “B”

Partners AM Group, Inc.
 800 Route 170A, Mahwah, NY 10940 845-341-8815 (F) 845-341-8814 (F)
 15 North Broadway, Suite D, White Plains NY 10601 914-285-0434 (F) 914-285-9816 (F)
 55 Old Nyack, Suite 401, Nanuet, NY 10954 845-624-3882 (F) 845-624-3992 (F)

Prescription Clearance Letter

Your patient is being evaluated for fitness to drive a commercial motor vehicle. He/she indicated taking a prescription medicine. It is important that commercial drivers have a full level of alertness while driving. If you believe that the prescribed medications will not adversely affect the driver's ability to drive safely, please complete the form below.

Driver's Company Name: Quality Bus Services

Cather Raibo is my patient, and is currently taking

(Patient Name)

Clonidine 1mg po BID Valued 1mg po 2-3x/day
AM & PM (Name of Medication, dose and frequency) afternoon & H.S.

The medication is taken: ☐ during work hours
☒ only during non-work hours

I certify that, in my professional judgment, this medication will not affect his/her ability to safely operate a commercial motor vehicle.

Physician's Stamp

Viviana Galli, MD
 Clinical Psychiatrist
 NY 238115
 DEA BG4789980

Pelli
 Physician's Signature

VIVIANA GALLI, MD
 Physician's Printed Name/License No.

10-16-12

Date